Initial Approval: October 12, 2016

CRITERIA FOR PRIOR AUTHORIZATION

Dipeptidyl Peptidase-4 (DPP-IV) Inhibitor Combinations Step Therapy

PROVIDER GROUP Pharmacy

MANUAL GUIDELINES The following drug requires prior authorization:
Alogliptin/metformin (Kazano®)
Alogliptin/pioglitazone (Oseni®)
Linagliptin/metformin (Jentadueto®, Jentadueto XR®)
Sitagliptin/metformin (Janumet®, Janumet XR®)
Saxagliptin/metformin (Kombiglyze XR®)

CRITERIA FOR PRIOR AUTHORIZATION APPROVAL (must meet all of the following):

- Patient must have a diagnosis of type II diabetes
- Patient must have a trial of concurrent use of generic metformin plus a DPP-IV individual agent for at least 90 days

LENGTH OF APPROVAL: 12 months

_____ _____

DRUG UTILIZATION REVIEW COMMITTEE CHAIR

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

_____ _____

DATE DATE